THE DISPLACEMENTS

OF THE

UTERUS;

THEIR CAUSES, NATURE, AND AN ACCOUNT

OF A

NEW PRINCIPLE OF TREATMENT.

BY J. S. SHANNON, CHICAGO, ILLINOIS.

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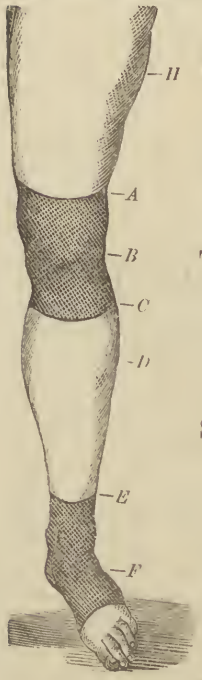

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THE DISPLACEMENTS

OF THE

WOMB.

In the whole range of medicine there is no subject upon which there exists a greater diversity of opinion in the minds of medical practioners, than that of the displacements of the womb. The ablest and most experienced disagree as regards their causation, pathology, and treatment. There is even a want of agreement as to the symptoms produced by these accidents; one set of authorities maintaining that the various pains, leucorrhœa, and disorders of menstruation usually found associated with them, are the result of the faulty position of the organ, while another set, equally able and conscientious, attribute these symptoms wholly to some accompanying disease involving structural change, as congestion, inflammation, or ulceration, and regard the displacement of the organ as of minor importance.

The cases of displacement of the womb which present themselves to the physician are usually of the chronic form, many of them having a history extending over several years, and it is unquestionable that in such cases there is always found more or less disease of the tissues of the organ. Generally it is impossible to decide which of these conditions has formed the first link in the chain of disorder, and, fortunately, such decision is not essential to proper treatment. We know that when displacement and structural disease of the womb exist together, the one reacts upon the other, and tends to its continuance. Thus, the unnatural position of the organ, by obstructing the circulation of blood in its tissue, produces congestion, with increased growth and weight, leading to inflammation and ulceration; and, on the other hand, the enlargement of the womb prevents it from regaining or maintaining its proper place in the pelvis; for, while the uterine supports may be quite sufficient to maintain the organ in its normal situation while it remains in a healthy state and of usual size, they become incapable of doing so under opposite circumstances. Hence it is, that any plan of treatment which does not

contemplate the removal of both the positional and structural disorder, where they are co-existent, must fail to be successful in a large majority of instances.

Inasmuch as all sure and safe methods of treating disease must be preceded by a knowledge of healthy function, so, in order to understand the nature and effects of displacements of the womb, we should first consider the organ in its natural position and relations.

The cut (Fig. 1) represents the pelvic organs of the female in their normal position.

Fig. 1.

Natural Position of the Female Pelvic Organs.

The womb is seen to occupy a central position in the pelvis, having the bladder in front, the rectum behind, the vagina below, and the intestines above. Its axis corresponds very nearly with a line drawn from the umbilicus to the extreme end of the spine, and forms a right angle with the axis of the vagina.

The womb is sustained in this position by the surrounding organs and tissues, and also by certain ligaments which extend from different parts of its walls to the neighboring bones.

The most powerful and important of these supports of the womb is unquestionably the vagina. This organ is not, in the ordinary condition of the parts, an open tube inviting, so to speak, the womb to drop into it. On the contrary, its anterior and posterior walls, except when pressed apart, lie in close contact with each other, forming in effect a solid column. This in its turn rests upon the perineum below, and so long as this latter structure remains intact, and there is no inversion of the vagina, one of the most frequent forms of displacement, prolapsus, cannot by any possibility occur.

The neck of the womb is sustained in its position chiefly by three powers, viz.:

1. Its attachment to the vagina.
2. The utero-sacral ligaments, which are attached to the upper portion of the cervix, on its posterior surface, and pass backward to be inserted into the sacrum.
3. The utero-vesical ligament, which passes from the anterior surface of the cervix-uteri to the posterior wall of the bladder.

The broad ligaments and round ligaments, attached to the body of the womb on either side, pass to the sides and front of the pelvis respectively, and tend to prevent the organ from falling backward; while the bladder in front performs a similar office in the opposite direction.

Nevertheless, the womb is a movable organ, and these structures which are called its supports do not by any means prevent its motion, but rather, by their softness and elasticity, pre-dispose to it. Each respiratory effort is accompanied by a rising and falling of the womb to a slight extent. It is, moreover, subject to a considerable degree of motion forward and backward, by the varying conditions of the bladder and rectum. The importance of a knowledge of this natural mobility of the organ will be made apparent when we come to the consideration of the treatment of the various forms of displacement.

Varieties of Displacements.

The womb is said to be displaced when the change from its natural position has become habitual or permanent. A slight deviation from its normal place, or even a considerable deviation when of temporary duration only, is not to be considered a displacement. For example, the organ may be depressed below its customary situation in the pelvis temporarily, as by a tightly-laced corset or dress, and on the removal of this cause it returns to its proper place. Such an instance would not properly be regarded as one of prolapsus. Or, the body of the organ may, from occasional distension of the bladder or rectum, be thrown backward or forward to a much greater degree than usual; and yet, if upon the removal of the displacing cause the organ resumes its normal position,

we cannot consider the case as one of retroversion or anteversion. So that *permanency of malposition is an essential element of displacement.*

The womb may be displaced in every conceivable direction. It may fall below its usual level, or it may rise above it; it may be tilted forward, backward, or sidewise; it may be bent in either of these directions; it may be twisted on its axis; or, finally, it may be turned inside out.

It is not necessary for the purposes of this paper that we should speak of all these varieties in detail, and we shall therefore only consider those which are of most frequent occurrence, viz.: prolapsus, anteversion, and retroversion.

Prolapsus of the Womb.

By prolapsus, or, "falling of the womb," is meant that condition in which the fundus, or upper portion of the organ, is habitually below its normal place in the pelvis. Other disordered states of the parts have also been termed prolapsus, which, however, are wholly different and distinct affections. For example, that portion of the neck of the womb which is above the insertion of the vagina, is sometimes greatly elongated, and in its downward growth in the pelvis carries the vagina with it. The os uteri, or mouth of the womb, is, of course, pressed downward also, and may be found sometimes just within the genital fissure, or even protruding beyond it, while the fundus of the organ occupies its usual position.

Again, this same result may occur from a similar development of the infra-vaginal portion of the neck, or that portion which is below the vaginal insertion. These are simply cases of excessive elongation of the cervix, a diseased condition certainly, but one to be distinguished from prolapsus, which implies the substantial descent of the whole organ, and not of a part of it. It is not the position of the os, therefore, but of the body of the womb, which is to be regarded as the diagnostic mark in prolapsus.

Causes. The causes of prolapsus of the womb are very numerous, and include,

1. Those influences which increase its weight, as inflammation, congestion, the development of tumors within its walls, polypi, etc.

2. Those which exert pressure upon it from above, as tight clothing, muscular efforts, abdominal tumors, etc.

3. Those which drag it downward, as prolapsus of the vagina, bladder, or rectum, polypi, or fibrous tumors of the cervix.

4. Those which weaken the uterine supports, as relaxation of the vaginal walls, rupture of the perineum, etc.

Mechanism.—Whatever may be the particular cause, or set of causes—for commonly there are several acting simultaneously—the successive steps of the displacement are essentially the same. First, the vagina,

or that portion of it which is attached to the womb, is carried downwards. This causes either an inversion of the vaginal canal, or a crowding together of its rugæ, thus shortening the organ. This is the only change produced, providing the womb do not descend more than about one inch. If it exceed this, however, the utero-sacral ligaments are put upon the stretch, and offer the second barrier to the further descent of the organ. These ligaments, as already stated, pass from the neck of the womb to the sacrum. They have a common insertion into the supra-vaginal portion of the cervix uteri, and thence, passing backward, separate to permit the rectum to descend between them. They then come together again behind the bowel, and are attached to the bone. In the ordinary condition of the parts these ligaments are lax, and produce no constriction of the bowel, but when they are made tense by traction, they are approximated and the rectum compressed, its circulation impeded, and its functions deranged. Thus it is that we explain the frequency of backache, constipation, and diseases of the rectum that are so commonly found accompanying long-standing cases of prolapsus.

If the womb be drawn downward by a force applied to the vaginal portion of the cervix, (the resistance offered by the vagina being first overcome, and the utero-sacral ligaments divided,) the cervix will be readily brought to the vulva, but its further descent will be prevented by another impediment which will be found to consist of the subperitoneal cellular tissue, which forms the third obstacle to the displacement under consideration. This tissue will be seen drawn at various points into tense bands, which are plainly discernable beneath the peritoneum.

These bands being next divided, the womb is easily drawn through the vulva, constituting complete prolapsus, or procidentia, and in this position the fourth and last impediment to its removal, namely, the round ligaments, are found to be on the stretch. The broad ligaments, with all their furniture of ovaries, Fallopian tubes, vessels, nerves, etc., accompany the womb in its downward progress, but at no stage do they exert any tendency to prevent it.

The foregoing illustration of the action of the various impediments to prolapsus, has been fully verified by experiments on the dead body, and they disprove many of the commonly received theories regarding the mechanism of this displacement.

Varieties.—Prolapsus of the womb may take place suddenly, or it may do so by slow and successive steps, and the symptoms produced by these

Fig. 2.

Diagram Representing the three Degrees of Prolapsus of the Womb.—(*Thomas.*)

two forms of the disorder differ only in the rapidity and severity of their development.

The first, or acute form, is of comparatively rare occurrence; while the latter, or chronic form, is of great frequency, and to it we shall confine our remarks. The affection may exist in different degrees or stages, three of these being commonly recognized. They are represented in Figure 2.

By reference to the diagram it will be seen that in the first degree, represented by the upper portion of the figure, the womb merely sinks downward and backward, retaining the normal direction of its axis, but that in the second and third degrees this latter undergoes a marked change. In the second degree the body has gone backward towards the sacrum, and the cervix, pushed downward and forward, reaches the sphincter muscle which closes the mouth of the vagina. In this stage the womb occupies a vertical position, and its axis corresponds with that of the person.

In the third stage the last barrier has been overcome, and the whole or part of the organ protrudes through the vulva, its axis coinciding with that of the outlet of the vagina, and forming a right angle with its own when in the normal position.

Symptoms. — The symptoms of prolapsus of the womb depend upon the results growing out of the displacement, including the mechanical interference of the displaced womb with the surrounding organs, and the disturbance of its own circulation and innervation by reason of its malposition. These symptoms consist of dragging pains, and sensations of weight in the pelvis; irritability of the bladder, manifested by frequent and painful attempts to urinate; disturbance of the functions of the rectum, producing constipation, hemorrhoids, ulceration, &c.; pains in the back and loins; fatigue in walking; inability to lift weights; leucorrhœa, and other signs of congestion. These symptoms are not all present in every case, and they vary in intensity very greatly in different women, and even in the same woman at different times. It is a well-recognized fact, too, that the severity of the symptoms does not bear any relation commonly to the degree of the displacement, some women suffering more from a mere depression of the organ below its accustomed place, than others who have the malady in its worst form, with the womb protruded and dangling between the thighs.

Even should all the symptoms enumerated be present in a given case, we are still not justified in deciding positively from their presence that

the patient is the subject of prolapsus, since it is quite possible for them to depend upon other causes. Hence, no case should be regarded or treated as one of prolapsus that has not been submitted to a physical exploration. The diagnosis of the displacements of the womb is so readily and certainly made, that no medical practitioner is excusable who neglects the only certain means by which this can be done. The time for "guessing" the existence or non-existence of uterine displacements has gone by, and an examination which will fully elucidate the case should always be made.

This exploration should always be made with the patient in a standing posture, her back resting against a wall, the knees moderately separated, and the body bent slightly forward. The necessity for this position of the patient will be at once evident, when it is remembered that in the recumbent posture a prolapsed womb at once returns to its normal place, or nearly so, in the pelvis, and that an examination made under such circumstances would lead to very erroneous results. The practitioner kneeling in front of the patient, or seated upon a low stool, should pass one or two fingers into the vagina. Should the affection exist only in the first degree, the os will be found low down in the pelvis and pressing upon its floor. The finger slid upwards in front of the cervix and along the base of the bladder, will distinguish the resisting anterior wall of the uterus, and may possibly discover that the prolapsus is complicated with anteversion or anteflexion.

If the disorder have attained the second degree, the os will be encountered at the mouth of the vagina, prevented from escaping, apparently, only by the restraining force of the sphincter muscle, and the womb to some extent retroverted.

In the third degree no error should possibly be made by the merest tyro. Sight and touch here combine to make the diagnosis rapid and easy. The organ, in whole or in part, is both felt and seen to be outside the vagina.

Diagnosis.—The only conditions at all likely to be mistaken for prolapsus are fibrous polypus of the womb, inversion of the organ, and the enlargement and elongation of the cervix, and from each of these it may be readily distinguished. Indeed an error can hardly be committed if its possibility be remembered.

From a fibrous polypus a prolapsus may be known by the presence of the os and cervix, and the general shape of the mass. From inversion, by the presence of the os, and the absence of hemorrhage and other symptoms of this affection. The great length of the cervix, and the depth of the cavity as ascertained by the introduction of the uterine probe, together with the impossibility of pushing up the organ into the pelvis, would sufficiently distinguish an elongated cervix from true prolapsus.

Complications. — The evils which follow in the train of a long-standing case of prolapsus are quite numerous. When the disorder has reached the second stage, and still more when it has reached the third, the tissue of the womb becomes congested, and appears swollen, soft and relaxed. This induces increased growth, and the organ becomes larger and heavier, and its walls thicker, harder, and more dense. The mucous membrane lining its cavity also becomes the seat of congestion, and this state soon passes into a chronic form of inflammation. The changes which take place in the cervix are quite peculiar. This part becomes particularly soft and spongy ; its vessels become varicose and enlarged, while the muscular tissue is in a great degree absorbed. The results of these changes are shown in the pain, leucorrhœa and disorders of the rectum and bladder. The attachment of this latter organ to the womb is so close that the one is always accompanied by the other in its descent. It is important to bear this fact in mind, for when it becomes necessary to introduce a catheter into the bladder, in a case of prolapsus, the instrument cannot be passed in the usual direction, upwards and forwards, but must be directed downwards and backwards.

This partial prolapse of the bladder has another important result, namely, the formation of a pouch of the posterior wall, which always retains a portion of urine, and the decomposition of this fluid, together with the traction exerted upon the bladder by the womb, frequently induces cystitis, a most serious complication.

Occasionally, though not so frequently, a similar process produces prolapse of the anterior wall of the rectum, with impaction of its contents.

Another complication of prolapsus, especially of the complete form, or procidentia, is the formation of that variety of ulcer denominated the inflammatory. This is distinguished by the depth of the sore, its precipitous edges, and its red angry-looking base. These ulcers arise from the exposure of the part to the air, and the friction and other injuries to which, under these circumstances, it is exposed.

Treatment. — We now come to the very important matter of treatment. And first, let us premise that our degree of success in curing this disorder will depend very much upon the condition of the uterus and vagina, apart from the positional disorder. Should the former be very greatly enlarged from the presence of a fibrous tumor in its walls, or other cause little amenable to treatment, no amount of support which the organ is capable of enduring will be found sufficient to sustain it. And, heretofore, the means in common use for supporting the organ, even when nearly of normal size and weight, have been found inadequate and unsatisfactory in cases attended with distension and thinning of the vaginal walls. However, in this last class of cases, we hope to show that there is much to be

hoped for from the use of the means of treatment to which we desire to call attention.

In every case of chronic prolapsus, whatever may have been the original cause producing it, there will be found a weakened condition of the uterine supports; and in almost every case this will be associated with increased weight of the displaced organ. Treatment must be directed, therefore, to the accomplishment of two objects, namely: 1. To diminish the weight of the womb, and protect it from downward pressure; 2. To strengthen the uterine supports.

The means at our command for the purpose of effecting the first of these objects consist of the following: 1. The prohibition of tight clothing; 2. The removal of the weight of the intestines; 3. The avoidance of lifting weights, and of making other great muscular efforts; 4. Prevention of accumulation in the bladder or rectum; 5. Removal of polypi, tumors, etc., by operation; 6. Removal of inflammation, congestion, and their results, by appropriate treatment.

One of the most common influences in inducing and maintaining prolapsus is the wearing of tight and heavy clothing supported from the abdomen and hips. In the normal condition of the parts, the important respiratory muscle, the diaphragm, rises and falls, and the base of the chest contracts and expands with each expiration and inspiration. If, however, the waist be tightly constricted by a belt, or corset, or tight clothing, the lateral expansion of the chest is prevented, and the diaphragm forces the intestines downward upon the movable uterus, pressing the latter organ down upon the floor of the pelvis. In addition to this force, several pounds of clothing are bound around the contracted waist, and held up by the hips and abdominal walls. The uterus is subjected to this pressure as much as fourteen hours of the twenty-four, and the effect of such baneful practice in producing prolapsus can be readily seen and understood. It seems hardly necessary to say that one of the first essentials to the cure of a case of prolapsus brought on or continued by such a state of things must consist in the removal of the cause. The clothing should be suspended entirely from the shoulders by means of a skirt-supporter, which consists simply of a pair of suspenders such as any ingenious woman can contrive for herself, or which may now be purchased ready-made of the dressmakers in any of our large cities; and the dress should be worn so loosely about the waist as to offer absolutely no impediment to the fullest inspiration.

The weight of the intestines may be greatly lessened also by the use of a properly selected abdominal supporter, in persons especially who have a prominent abdomen. Many of the contrivances sold under the name of abdominal supporters are not only useless but absolutely hurtful. To

be of benefit they should not reach above the navel, nor should their action consist in simply compressing the abdomen. Of course they cannot in any case have any influence in supporting the womb, that organ lying behind, and being shielded by the pubic bones. Their proper function is simply to take from the organ the undue weight and pressure of the abdominal contents, and in doing this they should act just in the manner of the patient's hands when she places them above the pubes and raises the lower abdomen.

The recumbent posture, persevered in for a sufficient time, would materially aid the use of the foregoing means; but besides the objection that very few women can afford to remain in their beds for six months or a year, another arises from the consideration that the loss of exercise thus entailed would have the effect of so greatly deteriorating the patient's general condition as to more than counterbalance any local benefit she might derive, and hence this mode of treatment is hardly expedient even where practicable. Confinement to the bed or lounge during the menstrual periods, however, at which times the uterus is heavier than at others, should always be insisted upon.

The second indication in the treatment of prolapsus, and the one of paramount importance, consists in the strengthening of the uterine supports. This is effected by the following means, namely :

1. Astringent substances applied to the vagina. 2. Certain surgical operations having for their object the lessening of the calibre of the vagina, or its outlet. 3. The use of pessaries.

Practically, the vagina is the only one of the supports of the womb within the reach of surgical means, and, as already stated, this organ forms, in its normal condition, the most important and effective obstacle to the descent of the womb; and, furthermore, while it retains its power and integrity the accident cannot occur.

Astringents. — The use of various articles for the purpose of temporarily constricting the vagina, and thus narrowing its canal and enabling it to sustain the uterus is a very old practice. The substances most commonly employed for this purpose are alum, tannin, persulphate and perchloride of iron, and the bark of the white oak. Any of these articles introduced by means of injection or suppository, have the effect, in many cases, of affording a considerable degree of relief, but in order to be in any degree successful, they must be used frequently, and the good effects cease when the use of the remedies is discontinued. In other words they do not *cure*, and worse than that their necessarily frequent employment by checking the natural secretion of the parts, often produces a state of engorgement and irritability which forbids their continuance.

Elytrorrhaphy. — This term is applied to certain surgical procedures which consist in the removal of a portion of the vaginal walls by the

knife or scissors, and the subsequent bringing together of the edges of the wound by means of stitches. A good deal of ingenuity has been expended in variously modifying these operations, in order to make them successful, but after all that has been done, they have not met with general favor among either patients or surgeons. The former are rarely found willing to undergo a severe surgical procedure, so long as any other means promise even a partial success; while the latter hesitate to recommend an operation which has been followed so rarely by success and so frequently by failure. Scanzoni, a recent and able writer on the Diseases of Females, states that he has performed this operation in eighteen cases, and adds, "but the results have not been at all satisfactory. The contraction obtained by elytrorrhaphy always yields in the course of a few weeks after the operation, in consequence of the pressure exerted by the uterus descending into the vagina, and the opening dilating more and more finally allows the uterus to pass through as before the operation."

These observations do not apply, however, to cases where the perineum has been ruptured, as frequently occurs during childbirth. Here the inferior support of the vagina itself is removed or impaired, and an operation to restore the integrity of the part must always be made if we expect a perfect cure. Without such an operation, indeed, the best means of support that can possibly be used will only be palliative. The operation, however, without additional support, will also only afford temporary relief, so far as the cure of the displacement is concerned, for the mere partial closing of the outlet of the vagina will have no more power to resist the pressure of the womb against it, than would the narrowing of the canal higher up. It is therefore indispensable that other means shall be used to effect a cure than those heretofore mentioned.

Pessaries. — Such means are pessaries. The idea of supporting the prolapsed womb by means of substances introduced into the vagina has an antiquity of many centuries, and pessaries, the name applied to these artificial supports, have been formed of almost every conceivable material, and in as great variety of shapes. They have been praised in the most extravagant terms by one set of practitioners, and as extravagantly condemned by others. While the first regard them as of paramount importance in the treatment of almost every case of displacement, the others deny their necessity in any, and consider them absolutely injurious in the majority.

While it may not be possible to reconcile views and opinions so diametrically opposed as these are, it does not seem a difficult task to assign some of the causes of their discrepancy.

The great mass of medical practitioners who attempt at all to treat diplacements of the womb habitually use pessaries. Experience has

shown them that unless they do use them they cannot do more than alleviate the sufferings of any of this class of patients, and in a large majority of them they are unable to do even this. But the very fact of this almost universal use of the instrument explains in some degree why it is that so many cases are unsuccessful, and why also so much injury has occasionally resulted from their employment. Any one who would attempt to fit a pessary should have some correct ideas of mechanics. So far as the mere fitting of the instrument is concerned the treatment is wholly a mechanical one, and unless it be properly fitted and adapted to the requirements of each particular case, it will be no more likely to result in the comfort of the patient than would a badly fitting shoe. The vagina is an organ that differs as much in size and shape in different women as does any feature of the face, or any other part of the body; hence it is as unreasonable to suppose that one size and pattern of pessary should fit every patient, as that one pattern of shoe should fit every foot, or one size of hat should fit every head.

Again, in order that one should be expert in the application of a pessary, a certain amount of experience is necessary; and it is to be expected that a practitioner who is in the habit of applying several hundred of these instruments in the course of a year, as is the case in large cities, should become more proficient than one who applies half a dozen in the same length of time.

The pessaries in most common use in this country are Hodge's lever and Meigs' ring, or their modifications, and they are deservedly the most popular, for the principle of their action is a great advance on anything that preceded them; but these, too, have radical defects, which prevent them from being so fully useful as a pessary should and can be. For example, these instruments derive their support inside the vagina, and necessarily distend that organ, leading the way, not to a radical cure by enabling its walls to contract, but producing the very opposite effect, so that when the patient seeks to abandon the use of the instrument, she finds herself frequently in a worse condition than before the treatment.

Again, these instruments (the same objection applies to both) frequently make injurious pressure against the bladder and rectum. Their mode of operation requires, as previously stated, that they *fill* the vagina, and in doing this they necessarily press against the neighboring organs, and this undue pressure induces disease. In some instances they have been known to do more than this — they have gone through the vaginal walls and *into* the neighboring parts. Hodge's pessary, for instance, has been known to "dig holes in the anterior walls of the vagina almost through to the bladder," says Sims; other pessaries have gone still further in the same direction and "caused grievous fistulas," according to the experience

of another observer; Sims has also known Meigs' ring to "cut a sulcus in the posterior cul-de-sac of the vagina, deep enough to burrow the finger in"; and Zwang's pessary (another of the pressing kind) to "sever the urethra from the neck of the bladder."

Of course accidents such as these may always be avoided with proper care, and the fault of their occurrence is rather in the person applying them than in the instrument itself. Yet, in view of the fact that pessaries are necessarily employed by many who have not had opportunity to acquire great experience, it is desirable that the instrument should be so simple in its style, and so adapted to its purpose, as to render it impossible for such injury to result from its use. Indeed a pessary should be such that it may be removed and replaced by the patient herself, for much of the injury that has followed their employment has been in consequence of their being permitted to remain too long a time without removal. Speaking on this point, Dr. Sims says: "A pessary is a thing to be worn like a glass eye, only when awake. As a rule it should be pulled off at night, and put on in the morning, if needed; and if every poor woman who is compelled to use such an aid for the support of the uterus, was always taught to understand the principle of its action, and to remove and replace it every day or two, there would be none of the accidents above alluded to, to damage their reputation for usefulness."

A pessary to be fully useful, and at the same time to produce a minimum degree of discomfort, should possess the following qualities, namely:

1. It should keep the uterus out of the vaginal canal.
2. It should produce no pressure against parts unaccustomed to pressure.
3. It should not distend the vagina.
4. It should be adaptable to every size and shape of the vagina.
5. It should be capable of removal and replacement by the person wearing it.
6. It should sustain the womb in the same manner as the organ is sustained by the normal vagina.
7. It should be composed of a material which will not become changed by contact with the uterine and vaginal discharges.

We will consider these points somewhat in detail.

A pessary *should keep the womb out of the vagina.*—We have already said that the vagina was the most important and efficient of all the supports of the womb, and that prolapsus of the latter could not occur so long as the former maintained its natural position. We have now to add that if the vagina be relaxed in its tissue, shortened, or in any degree inverted, prolapsus of the womb to some extent must almost certainly take place, for the vagina being firmly attached by its upper extremity to

the uterine neck, will inevitably in such case draw the womb downward with it, or permit it to descend.

Hence, it follows that any pessary which does not restore the vagina to its proper length, must fail in its purpose; and, further, that if the vagina be restored to its proper length, the womb will necessarily resume its proper position also.

A pessary *should produce no pressure against parts unaccustomed to pressure.* — When the womb is in its proper position, only a small portion of the cervix, usually not more than half an inch, is within the vagina, and the entire organ is situated so high in the pelvis as to be incapable of making any pressure against the bladder or rectum. As already stated, many of the distressing symptoms accompanying prolapsus of the womb arise from the pressure of the displaced organ against these neighboring parts, and the consequent interference with their functions. The effects of such pressure are precisely the same, whether it be made by the womb, or by an instrument placed in the vagina; and yet how many pessaries there are that do exactly this thing. All the vast array of disks, globes, sponges, balls, and inflating pessaries, act in this manner, and consequently, while they may be efficient in supporting the womb, they do so chiefly by filling the vagina, and the pressure against the bladder and rectum is no less than when that organ is filled by the womb.

Quite as improper and injurious as the classes of pessaries just named, are those which support the womb by pressure against the cervix. This portion of the womb is naturally merely suspended in the vagina, and in the normal condition of the parts does not press even against the soft walls of the latter organ; and it is well known how quickly it becomes the seat of congestion and ulceration from injury during coition. A knowledge of these facts prepares us to understand the evils that result from the use of pessaries whose mode of action is to sustain the womb by receiving the cervix into cups of unyielding substances, as hard rubber or metal.

A pessary should not produce distension of the vagina. — In order that the vagina shall be an efficient support to the womb, its walls must be in contact with each other. So long as it remains in this condition it forms a firm column, but when its walls are separated it becomes an open canal, and ceases to be a support except by the tonicity of its walls. When the tissue of these latter becomes relaxed they cannot sustain the womb at all, but, on the contrary, aid its descent. Distension induces relaxation and debility, and a patient who has worn a pessary which distends the vaginal canal finds herself at the end of a year's treatment further from the cure she seeks than she was at the commencement.

A pessary should be adapted to every size and shape of the vagina. — We have already alluded to the fact that the vagina is as various in its size, shape and other features as any other part of the body. It varies in its width, its curvature and its length. These peculiarities should be considered and conformed to in the adaptation of an instrument that is to occupy it for probably many months. Otherwise we may expect that pain, irritation and discomfort will be continued or increased rather than mitigated. It must not be inferred from this, however, that the calibre of the vagina is to be *fitted* with an instrument; on the contrary, we hold that whatever may be the degree of distensibility of its walls, or the amount of dilatation they may have been subjected to, no pessary should prevent them from being approximated if it would be curative. The degree of curvature, however, should be regarded; and still more important is it that the length of the vaginal canal be taken into account. This last is necessary in order that our appliance may not put it on the stretch, thus distending and weakening its walls; or, on the other hand, that it may not fail to elevate the womb to its proper position.

It should be a governing principle in the application of any artificial uterine support, that the womb be not held rigidly even in its normal position. It should be permitted to have as much freedom of motion, except in the direction of the displacement, as it has in the natural condition of the parts. Otherwise the organs must necessarily be subjected to undue and injurious pressure.

A pessary should be capable of removal and replacement by the person wearing it. — Many instances have been recorded in which great injury has resulted from permitting a pessary to remain for long periods of time without removal. The patient, in some of these cases, doubtless felt a degree of comfort and relief from the presence of the instrument, to which she had for a long time been a stranger, and had no desire to have it removed; and not understanding the necessity for such removal, would allow weeks, months, and in some instances years, to elapse, until its presence came to be disregarded or even forgotten.

Where patients are instructed as to the injury likely to result from such neglect, they would doubtless generally feel disposed to obey, providing they felt assured that they could remove and reinsert the instrument themselves; but if such removal involves the calling in of the physician, they are quite likely not to do so. Ordinarily it is best to remove the instrument at night on retiring to bed and replace it before rising in the morning; and such frequent removal and replacement as this, would be impracticable usually unless it could be done by the patient. The necessity, therefore, for an instrument which *cannot go wrong*, and which the patient can use without assistance, is manifest.

As every practitioner is aware, many of the instruments in use, especially those bearing the names of Hodge and Meigs, with their modifications, require a greater amount of skill in their adjustment than most women are likely to acquire, and hence these instruments are permitted to remain for longer periods than is proper, and, consequently, more injury has resulted from their use, or rather from this kind of abuse, than from any others.

A pessary should sustain the womb in the same manner as the organ is sustained by the normal vagina. — In all our endeavors to cure disease, defects, or disorders of any kind, affecting the human organism, we should imitate, so far as this may be possible, Nature's own plan for doing the same thing. In the disorder under consideration, this is an especially important principle to keep in view, and the neglect of it may be regarded as the key to many of the failures and injuries that have resulted from the use of pessaries. The womb is prevented from descending in the pelvis, as has been already shown, chiefly and primarily by the vagina. This latter organ at its upper extremity surrounds the cervix uteri to which it is firmly attached, and the womb is maintained in position by the tonicity of the vaginal walls — not on one side only, but on every side. This fact should be a guide to our practice when we come to treat prolapsus. All this ring of vagina which surrounds the cervix should be carried up to its normal place, and this action necessarily results in the drawing up of the uterus. We can now see how partial and one-sided is the action of the Hodge and Meigs' instruments, both of which lift up the posterior cul-de-sac only, and the womb is sustained on one aspect only, while its entire weight is caused to press against only that portion of the sustaining instrument — comparatively a mere point—that holds up the posterior wall. This is essentially wrong. The anterior and lateral walls of the vagina should all be supported and sustained as well as the posterior, and then the uterus is carried naturally into position, and maintained there naturally, while the weight of the organ is equally distributed upon the whole circumference of the vaginal ring.

Pushing the prolapsed organ upwards by direct pressure against the cervix, is likewise a most unscientific and sometimes injurious method. As already stated, this structure is not adapted to endure continuous pressure, and when subjected to it the result has been in many instances to cause ulceration, inflammation, and induration of the tissues.

A pessary should be composed of a material which will not become changed by contact with the uterine and vaginal discharges. — The mucus which is discharged from the cervical canal has an alkaline reaction, while that from the vagina is acid. Hence no substance should be used as a pessary which is liable to change or injury by contact with agents having these

chemical characters. Neither should organic substances be used which are liable to decomposition, or which, by retaining the discharges, enable them to become decomposed. There is no substance at present known to us, that seems so fully to answer all the requirements for the purposes of a pessary as the hard, black rubber. This substance is capable of receiving a very high degree of polish, the lustre of which is not dimmed by remaining for an indefinite length of time in the vagina, even in case of patients who have the most virulent forms of leucorrhœa. Neither is it acted upon chemically by the discharges from the parts. And, finally, it may be moulded into any desired shape by simply immersing it for a few minutes in hot water, or holding it over the flame of a spirit lamp. *

We have now enumerated the requisites of a perfect pessary, and have briefly considered the reasons why we regard them such. Having done so, we can truthfully add that, although tolerably familiar with the subject, we are not acquainted with any pessary that meets all these indications, except the one which we have now to introduce to the profession.

Fig. 3.—SHANNON'S SELF-ADJUSTING PESSARY.

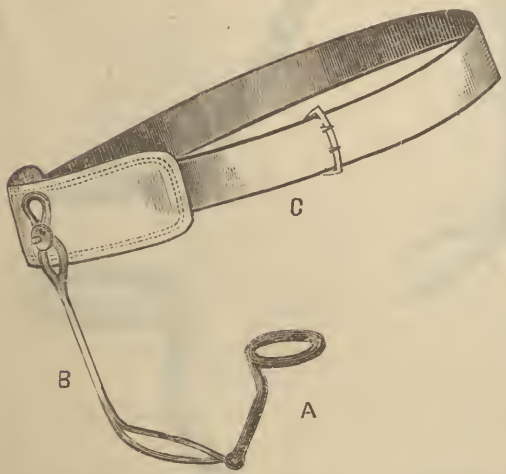


Figure 3 represents the instrument, one-fourth size, as arranged for a case of prolapsus. It consists of three parts,—A, the Stem ;—B, the Spring, and C, the Belt.

The Stem is composed of hard rubber, and consists of a ring and a shaft. When in place, the ring receives the cervix uteri, and passing onward fits into the vaginal cul-de-sac. The ring should be so adapted in size as to produce no possible constriction of the cervix, but allow the

* To a person who has not had experience in conducting this operation, a word of caution may be necessary. If hot water be used for the purpose of softening the rubber, only that part of the stem in which the change is required should be immersed. When the proper alteration has been made, the instrument should be held firmly in the required shape until it is cooled. This cooling may be hastened by dipping it in cold water.

In case the flame of a spirit lamp be the heating agent, great care is necessary in order that the rubber be not burned or blistered. The portion to be bent should not be held nearer the flame than three or four inches.

latter to play loosely in it. As a rule the calibre of the ring should be at least a quarter of an inch greater than the greatest thickness of the vaginal portion of the cervix. The stems are constructed with rings of many different sizes so as to adapt them to any sized cervix. The shafts of the stems are also of various lengths, in order to accommodate them to any length of the vaginal canal. The degree of curvature of the shaft, and also the angle at which the ring is placed upon it, may be changed in a few moments by heating the stem in hot water as already explained.

Fig. 4.
Stem of Pessary for Retroversion.

Fig. 5.
Stem of Pessary for Anteversion.

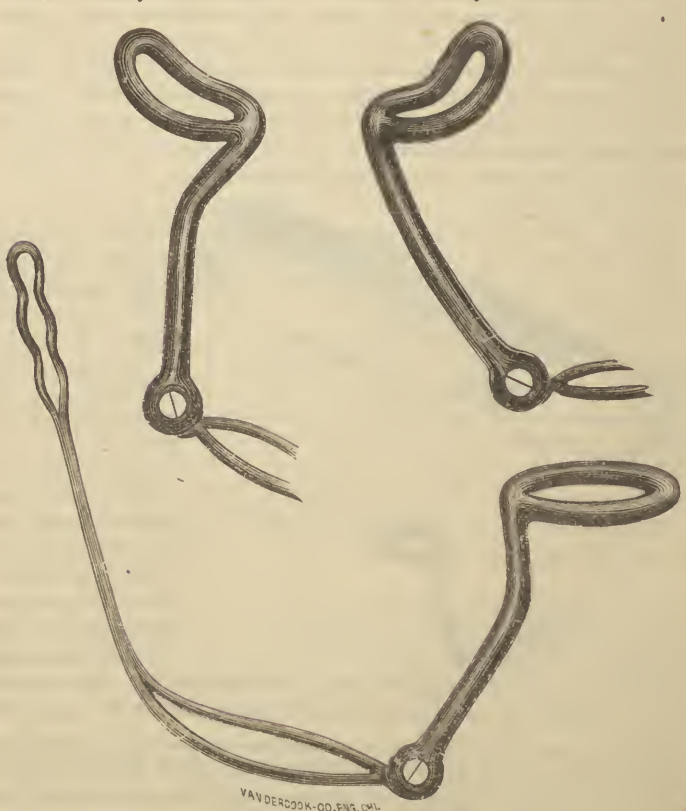
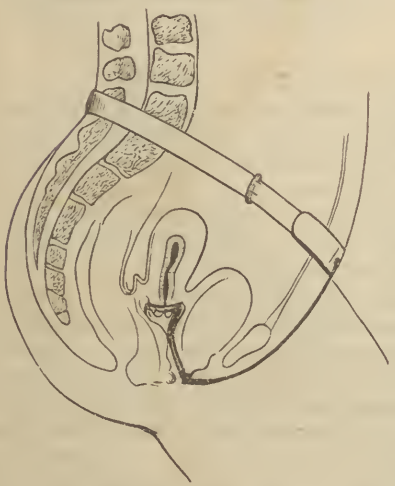


Fig. 6.
Stem and Spring for Prolapsus.

Figures 4 and 5 represent the stems of the instrument as modified for the treatment of retroversion and anteversion of the womb, respectively; and Figure 6 represents the stem and spring as usually required for prolapsus.

The Spring is constructed of pure coin silver. It is sufficiently firm to maintain the womb in its proper position under all the varying motions of the body, and yet is so pliable as to permit the organ to rise and fall with each respiration, or during the act of sneezing, coughing, etc. We thus avoid any danger from fixing the organ rigidly in the pelvis, thus subjecting it to possible injury between two opposing forces. In short, by this contrivance we obtain all the benefits claimed for the lever pessary without incuring the evils of vaginal pressure, which are inseparable from the Hodge instrument.

Fig. 7.—DIAGRAM REPRESENTING SHANNON'S PESSARY APPLIED TO A CASE OF PROLAPSUS.



The natural movement of the womb backward and forward is also provided for by the peculiar manner in which the stem is attached to the spring. This attachment is made by means of a movable screw-joint, which permits the cervix to advance or recede with all the varying conditions of the bladder and rectum. If for any reason it should be desirable to prevent this mobility of the womb, the object may be readily effected by tightening the screw, whereby the stem and spring may be as firmly united as though they were formed of a single piece. This change, however, can rarely be necessary, and usually the womb should be permitted to have all its normal movements untrammelled.

The Belt is merely for the purpose of affording a point of support and attachment for the spring. It should never be worn so tightly as to produce the least constriction of the abdomen.

In applying the instrument, the belt should first be buckled loosely

around the person. Then the patient should lie upon her back, and one or two fingers of the left hand of the operator introduced into the vagina, should gently and steadily restore the womb to its proper position. The stem, attached to the spring, should then be taken in the right hand and passed into the vagina, the ring being guided to its proper place by the finger already introduced. The spring is next brought forward and attached to the belt, and the operation is then complete.

When the instrument is perfectly adapted to the particular case, the screw-joint will be found occupying a central position between the labia majora, or larger lips of the vulva. Should the stem press against either the anterior or posterior junction of the lips, pain and irritation will inevitably be produced. In case the stem should be found pressing forward against the clitoris, the remedy will consist in increasing the curvature of the lower part of the spring; and if, on the contrary, it should press against the posterior commissure, the spring should be straightened. The spring may readily be bent between the thumbs and fingers, and the change in the curvature should be made *only at the lower branching, or double portion of the spring.*

ANTEVERSION AND ANTEFLEXION OF THE WOMB.

Anteversion is the name given to a displacement of the womb which consists in the falling forward of the body of the organ against the bladder, the cervix being at the same time thrown backward and upwards towards the promontory of the sacrum. The causes which produce this displacement are many of them the same as those which induce prolapsus. They consist of those influences which increase the weight of the uterus, weaken the uterine supports and finally drag the fundus forward.

Diagnosis. — There should be no difficulty in ascertaining the presence of this displacement, if proper diagnostic means be used. A finger passed into the vagina fails to find the cervix uteri in its normal position; indeed one finger will generally fail to reach it at all. Deep exploration, however, made with the index and middle fingers will discover it high up in the hollow of the sacrum, while a hard ridge-like tumor will be felt lying against or even below the edge of the symphysis pubis. If pressure be now made with the disengaged hand upon the hypogastrium at the same time that the tumor is pressed upwards by the fingers in the vagina, it will be found to consist of the body of the womb. This will usually be considered sufficient evidence of the condition present, but if not, a probe may be passed into the uterine cavity by being very much curved forward, thus completing the diagnosis.

It is probable that most of the cases of anteversion met with in practice are cases of antcflexion also; that is, the body of the womb is not

only inclined forward, but the organ is bent upon itself, the body forming an angle with the cervix. Indeed these two conditions are so generally found combined that it is common in works on the diseases of women to consider them together.

The degree of the flexion in these cases is very variable. It may exist in a very slight degree, and form a mere curvature of the organ, or, in extreme cases the womb may be completely folded upon itself, making the angle of flexion very acute. When the disease is very old and strongly marked, adhesions of the womb to the walls of the pelvis, or to the neighboring organs are frequently present. These adhesions are formed by bridles of cellular tissue, and are the result of previous inflammation of the peritoneum. The connecting bands or bridles vary very greatly in size and length. When they are very short and proceed to the anterior wall of the pelvis, it is evident that they must interfere with the mobility of the organ and render reduction impossible. Such cases are, of course, incurable.

Fig. 8.—DIAGRAM REPRESENTING THE APPLICATION OF SHANNON'S PESSARY FOR ANTEVERSION OF THE WOMB.

Symptoms.—The symptoms produced by anteversion and anteflexion of the womb are chiefly those which result from any accompanying disease of the womb, as inflammation, ulceration, etc.; and those which arise from the undue pressure against the bladder. The pressure of the os uteri against the rectum induces dysmenorrhœa, sterility, and occasionally tenesmus and irritability of the bowel.

In some instances anteversion may exist in a marked degree without creating either local or constitutional disturbance.

Treatment.—The treatment consists, 1st. In the removal of any existing cause, and 2d. In restoring and maintaining the organ in its proper position. The means necessary for the first indication will be suggested of course by the peculiarities of each case, while for the second we believe that our pessary will be found superior to any mechanical

appliance yet proposed for the purpose. In order to adapt it to the end in view, it should be arranged as represented in Figure 5, with the curvature of the stem reversed, and the ring at a much more acute angle with the shaft than is proper for prolapsus. This enables the free edge of the ring to be placed in the anterior cul-de-sac, where it receives the weight of the body of the organ, restoring and maintaining it in proper position, and preventing any pressure from coming against the bladder. At the same time the cervix uteri, being engaged in the ring, is drawn downward and forward to its proper place in the vagina.

Retroversion and Retroflexion.

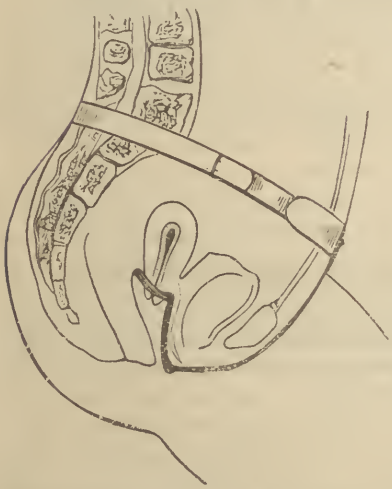
These conditions are the reverse of those just considered. In retroversion the body of the womb is inclined backward so that it rests in the hollow of the sacrum, while the cervix is carried forwards and upwards. When the organ is retroflexed, the os uteri is frequently found occupying its normal position, while the body has the backward inclination, as stated.

Symptoms. — There are, perhaps, very few cases of retroversion or retroflexion of the womb that are not accompanied or produced by some disease of the organ. While anteversion and anteflexion are favored by the natural forward obliquity of the womb, and may be brought on simply by the pressure of the abdominal contents forced downward by tight clothing or muscular efforts, this is rarely true of the affections under consideration. Here some diseased change in the womb or its appendages are usually the first steps in the disorder. Anteversion is most frequent in the unmarried; retroversion and retroflexion, on the contrary, occur oftener among women who have borne children.

A moment's reflection will show why this is the case. Among the causes which produce retroversion are, prominently, increased weight of the womb, relaxed support and abdominal pressure. Pregnancy and parturition furnish two of these causes, and the usual method of treating lying-in women furnishes the third. I allude to the injurious practice of compelling a woman to lie persistently upon her back for several consecutive days, in obedience to the superstition of monthly nurses, who believe that their reputation for care and skill would at once be questioned should they permit the patient to turn upon either side. When the woman is lying upon the back, the heavy fundus of the womb tends to fall directly back into the hollow of the sacrum, and this result, if at all doubtful, is made certain by the application of the binder. The ostensible purposes of this last named appliance are the prevention of hemorrhage and the preservation of the "figure" — its real effect is, too frequently, retroversion of the womb.

Diagnosis. — The diagnosis of retroversion is not difficult. A finger introduced into the vagina discovers a rounded tumor occupying the space between the vagina and rectum, and which is found to be the body of the womb by the introduction of the sound, which, instead of passing in the usual direction, must be introduced with the convexity of the curve pointing forward.

No. 9.—DIAGRAM REPRESENTING THE APPLICATION OF SHANNON'S PESSARY FOR RETROVERSION OF THE WOMB.



Treatment. — Any existing disease having been removed by appropriate treatment, the womb should be restored to its proper position, and a Self-adjusting pessary, modified as shown in Figures 4 and 9, introduced. The ring should be bent at such an angle to the shaft of the stem as to produce slight pressure against the body of the womb in the posterior cul-de-sac. This pressure should be very moderate, in order to avoid injury to the parts. Commonly the instrument should not elevate the fundus more than half an inch from its malposition during the first week of treatment. At the end of this time, or whenever tolerance of its presence is fully established, the ring may be elevated a little more, and so on, from time to time, until the organ is fairly in place. The instrument should always be worn several months afterwards, however, in order to permit the natural supports to fully regain their power, and thus prevent a relapse.

SHANNON'S

SELF-ADJUSTING UTERINE SUPPORTER,

FOR THE RADICAL CURE OF

PROLAPSUS, RETROVERSION AND ANTEVERSION,

Is unquestionably the best instrument now in use for all displacements of the womb, because it is simple in construction, and *perfectly* adapted to the parts, producing no pressure upon the neighboring organs. It is light, durable and elegantly made, and will last a life-time. It need not be removed when there is a movement of the bowels or micturition. It has no strings or straps to hold it in place, and to become foul and offensive, but is held in position by a pure coin silver spring, that will not even soil the whitest linen.

A Few Suggestions to Physicians in Ordering an Instrument.

Great care should be taken to ascertain the proper size in each particular case; if the ring is too large or too small it cannot be worn with comfort. The ring should be so adapted in size as to produce no possible constriction of the cervix, but allow the latter to play loosely in it. As a rule the calibre of the ring should be at least a quarter of an inch greater than the greatest thickness of the vaginal portion of the cervix. The rings vary in size from 1, 1¼, 1½, 1¾, 2 and 2¼ inches, attached to stems varying from 2¼ to 3½ inches. Care should also be taken in the selection of the stem, so as not to put the vaginal canal on the stretch. These instruments are numbered as follows: 1, 2, 3, 4, 5 and 6. Nos. 3 and 4 are used in the majority of cases.

If this pamphlet should chance to fall into the hands of any woman suffering from any of the ailments above mentioned, she should before attempting to apply the remedy herein suggested, consult her family physician.

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A FEW TESTIMONIALS FROM PHYSICIANS EMINENT IN THE PROFESSION.

Reference is made to Prof's BYFORD, A. REEVES JACKSON, R. LUDLAM, and A. J. BAXTER, of this city.

LENA, ILL., June 16th, 1873.

MR. JAMES S. SHANNON:

Dear Sir—I have just heard from the Supporter you furnished me with and am pleased beyond my most sanguine expectations. The lady has been a sufferer for some years with Prolapsus. She has had a practical trial of some of the latest Supporters, but could not tolerate them owing to the tenderness of the os; this the ring obviates, and owing to its flexibility enables the physician or patient to adapt it to the parts. I am satisfied that upon trial it will supersede the Supporters now in vogue.

Yours Truly,

THOS. L. CAREY, M. D.

POSTVILLE, IOWA, April 22, 1873.

MR. J. S. SHANNON:

Dear Sir—Yours of the 5th inst., having been delayed is at hand. In reply to your inquiries, I am pleased to state that the Supporter furnished by you has positively effected a RADICAL CURE of a most distressing case of Prolapsus, in a patient of near 50 years, whose life had been for ten years almost a burden. I have seen and tried most of the late inventions in the line of Supporters, but I am free to say that yours stands first in my estimation.

Truly Yours,

L. BROWN, M. D.

LOUISVILLE, KY., July 22, 1873.

DR. W. ROGERS:

Dear Sir—Upon your recommendation I have used a number of Shannon's Improved Uterine Supporters, and take great pleasure in assuring you that they have met my most sanguine expectations. I consider them a valuable adjuvant in the treatment of Uterine diseases, and well worthy the serious consideration of the medical profession.

Your Obd't Servant,

H. C. LLOYD, M. D.

MACON, GA., July 23d, 1873.

W. ROGERS, M. D,, Louisville, Ky.:

Dear Sir—Your letter of July 13th is at hand and contents carefully considered. The three Supporters were received by express in good order. They are neat and carefully made and in my opinion well adapted for the treatment of the diseases for which they were made. Hoping you success, I am,

Very Respectfully, &c.,

GEO. N. HOLMES, M. D.

MT. MORRIS, OGLE CO., ILL., July 15th, 1873.

MR. J. S. SHANNON:

Dear Sir—I have used Shannon's Improved Self-Adjusting Uterine Supporter in my practice, and I think it is the best and most perfect of any that I have ever used. I think it a God-send and blessing to those afflicted with any displacement of the Uterus.

DR. JOHN McCOSH.

LOUISVILLE. April 6, 1872.

DR. ROGERS:

You sent me one of Shannon's Supporters, with the request that I would give it a fair trial. I applied it to a case similar to the one in which I first used Babcock's; an account of which I published in the *Philadelphia Medical and Surgical Reporter*. Each of the cases was of the worst form of Procidentia Uteri, and had lasted several years. Shannon's answered all indications required, and being so much cheaper than Babcock's, I will be glad to use it in future.

Yours,

J. J. O'RIELLY, M. D.

April 29, 1872.

J. S. SHANNON:

Sir—I ordered one of your Uterine Supporters, which I applied in the case of a lady who has been afflicted with Procidentia of the Uterus for a period of over two years, in which case every appliance known to the profession has been brought into requisition, but to no avail. As soon as the instrument was applied she arose from a bed to which she had been confined for several months, and declared that she was as well as she ever was in life, and perfectly easy. She has worn the instrument for a period of some six months with the most satisfactory results. I shall never think of using any other, as we know this to be the desideratum long sought for. Send one by express, C. O. D., to my address, Temperance Mount, Simpson Co., Kentucky.

Yours Respectfully,

W. E. ARNOLD, M. D.

CLINTON JUNCTION, WIS., March 24, 1872.

MR. SHANNON:

Dear Sir—I think your Supporter the best out. The one sent me has given complete satisfaction in its fit and ease. Other kinds have been tried in this case but could not be worn. I have shown your instrument to many physicians who have been opposed to all uterine supporters, but think favorably of yours and say they will try it as soon as an opportunity presents itself.

Yours Respectfully,

R. BACKUS, M. D.

MEMPHIS, March 5th, 1872.

Dear Sir—I have given your "Self-Adjusting Uterine Supporter" a fair trial, and regard it a perfect success. Please send me by express ½ dozen medium sizes, C. O. D. Send soon as possible and much oblige,

Yours Truly,

J. R. WILSON, M. D.

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